ACI Enterprises Inc.
6480 Weathers Place, Suite 300, San Diego, CA 92121
ACI Clinical Dept: clinical@acispecialtybenefits.com
Tel: (800) 932-0034 | Fax: (858) 964-0733

SUPERVISORY REFERRAL FORM

PLEASE PRINT OR TYPE

Employee Name:	**Company:**	
Work Location:	**Position:**	
Employee Phone #:	**Employee Email:**	**Date of Referral Submission:** / /
Reason for Referral:		

☐ **Standard Referral**	Contact a provider within 2 business days of the date above and schedule an appointment within 3-5 business days
☐ **Urgent Referral***	Contact a provider by the end of business day immediately following above date and schedule an appointment within 2-5 business days

***Mark urgent only when employee is in imminent danger of harming self or others, produces positive drug screen, or (s)he is placed on leave until assessed by a provider.**

I understand and agree that a condition of continued employment may be that I contact a provider of ACI Specialty Benefits at 1 (800) 932-0034. I will complete the course of treatment as recommended or arranged through the provider, and cooperate with any such treatment, counseling or care. I acknowledge that my signature below indicates my acceptance of these terms.	**Employee Zip Code:**
	Date: / /
Employee Signature:	

HR/Supervisor Signature:		**Date:** / /
HR/Supervisor Name:	**HR/Supervisor Phone #:**	**HR/Supervisor Email:**

PRINT FORM

SUBMIT FORM

ORIGINAL: HR/Supervisor
COPY: Employee

Fax: (858) 964-0733
Email: clinical@acispecialtybenefits.com

www.acispecialtybenefits.com

EAP employee assistance | CORE wellness | LEVERAGE concierge | SOAR student assistance

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RELEASE OF INFORMATION AUTHORIZATION

PLEASE PRINT OR TYPE

HR/Supervisor: Please fill out Section 7 ONLY.
Employee: Please fill out Sections 1 and 2 ONLY.

SECTION 1: Employee Information

Last Name:	**First Name:**	**Middle Initial:**	**Date of Birth:** / /
Street Address:	**City:**	**State:**	**ZIP Code:**

SECTION 2: Review Sections 1 through 8, Then Sign Below

I have read the contents of this form. I understand, agree and allow the use and release of my information as I have stated below. I also know that signing this form is of my own free will. I know that the person or company listed in Section 6 does not require that I sign this form in order for me to get treatment or payment, or to sign up for or get benefits. I also know that information that is released may be also given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule.

Employee Signature:	**Date:** / /

SECTION 3: Date Your Approval Expires

Your approval will end one year from the day you sign above.

SECTION 4: Right to Withdraw Your Approval

I have the right to take back my approval at any time by giving written notice to the office listed below. I understand that if I take back this approval, any prior approval that I have already given cannot be withdrawn.

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SECTION 5: Reason for the Release of Information

By signing this form, you will allow ACI to use and give out the information below for the following reasons:

- Assessment to treating professionals only
- Treatment planning
- Determination of compliance with recommendations
- Coordination and continuity of care
- Contract for Continued Employment (CCE)

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SECTION 6: Person, Company or Group Allowed to Release the Information

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6480 Weathers Place, Suite 300
San Diego, CA 92121

SECTION 7: Person, Company or Group Allowed to Receive the Information

- Employee Assistance Program professionals
- Treatment providers
- Employer representative (enter employer name, representative name and title below)

Employer Name:

Representative Name:	**Title:**

SECTION 8: Information Being Released

I approve the following information to be used or given out to the person or company as shown on this form:

- Treatment recommendations to treating health professionals only
- Compliance and/or non-compliance with recommendations
- EAP contact and attendance

I understand that my alcohol/substance abuse information is protected under Federal and State confidentiality laws and regulations. I know it cannot be given out without my written consent unless otherwise provided for in the laws and regulations. I also know that I may withdraw (or cancel) my consent at any time, or as described above in Section 5. I know that I cannot cancel this consent where this form has already been used to give out information.

For Receiver of Substance Abuse Information

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Please return the completed form to:
ACI Specialty Benefits
6480 Weathers Place, Suite 300
San Diego, CA 92121

OR

Fax completed form to:
(858) 964-0733

OR

Email completed form to:
clinical@acispecialty benefits.com

PRINT FORM **SUBMIT FORM**